STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING _____ B. WING _____	C 10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	**255 MEADOW DR DANVILLE, IN 46122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for an investigation of Complaint IN00181497.

This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaint IN00178593 completed on August 21, 2015.

Complaint IN00181497 - Unsubstantiated. Allegation did not occur.

Survey Dates: October 5, 6, and 7, 2015.

Facility Number: 000057
Provider Number: 155132
AIM Number: 100266570

Census Bed Type:
SNF/NF: 62
Total: 62

Census Payor Type:
Medicare: 13
Medicaid: 37
Other: 12
Total: 62

Sample: 4

Danville Regional Rehabilitation was found to be in compliance with 42 CFR Part 483, Subpart B and IAC 16.2-3.1 in regard to the investigation of Complaint IN00181497.

Quality review completed 10/9/15 by 29479.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE